No.

IN THE

Supreme Court of the United States

OCTOBER TERM, 1989

MARVIN NEIMAN d/b/a
CONCOURSE NURSING HOME,

Petitioner,

vs.

SECRETARY OF THE UNITED STATES DEPARTMENT
OF HEALTH AND HUMAN SERVICES, and
THE TRAVELERS INSURANCE COMPANIES,

Respondent.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES SUPREME COURT FROM THE COURT OF APPEALS FOR THE SECOND CIRCUIT

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Questions Presented

1. Whether a party is entitled to a forum for review of a federal actor's refusal to review a Medicare determination.

2. Whether a party may be deprived of his federal right to challenge federal actors pursuant to a rule which states that he must first resort to "fair hearing" where he has been consistently denied any review determination, let alone a "fair hearing."

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TABLE OF AUTHORITIES

Opinions Below

The opinions of the District Court for the Eastern District of New York are reported at ____ F. Supp. ____, 1989 WL 119733 (E.D.N.Y.) and ____ F. Supp. ____, 1989 WL 119734 (E.D.N.Y.). The Order of the Court of Appeals of the Second Circuit is not reported.

Jurisdiction

The judgment of the Court of Appeals for the Second Circuit was made and entered on September 15, 1989 and copies thereof are appended to this petition in the Appendix. The jurisdiction of this Court is invoked under 28 U.S.C. §1254(1).

STATUTES, FEDERAL RULES AND REGULATIONS

U.S. Constitution Amendment V

No person shall be held to answer for a capital, or otherwise infamous crime, unless on a presentment or indictment of a Grand Jury, except in cases arising in the land or naval forces, or in the Militia, when in actual service in time of War or public danger; nor shall any person be subject for the same offence to be twice put in jeopardy of life or limb; nor shall be compelled in any criminal case to be a witness against himself, nor be deprived of life, liberty, or property, without due process of law; nor shall private property be taken for public use, without just compensation.

42 U.S.C. § 405(h). Finality of Secretary's Decision

The findings and decision of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Secretary, or any officer or employee thereof shall be brought under section 1331 or 1346 of Title 28 to recover on any claim arising under this subchapter.

42 U.S.C. § 1395ff. Determinations of Secretary

[as applicable at the time the claim arose]

(a) Entitlement to and amount of benefits

The determination of whether an individual is entitled to benefits under part A or part B of this subchapter, and the determination of the amount of benefits under part A of this subchapter, shall be made by the Secretary in accordance with regulations prescribed by him.

(b) Appeal by individuals

(1) Any individual dissatisfied with any determination under subsection (a) of this section as to—

(A) whether he meets the conditions of section 426 or section 426a of this title, or

(B) whether he is eligible to enroll and has enrolled pursuant to the provisions of part B of this subchapter, or section 1395i-2 of this title, or section 1819, or

(C) the amount of benefits under part A of this subchapter (including a determination where such amount is determined to be zero)

shall be entitled to a hearing thereon by the Secretary to the same extent as is provided in section 405(b) of this title and to judicial review of the Secretary's final decision after such hearing as is provided in section 405(g) of this title.

(2) Notwithstanding the provisions of subparagraph (C) of paragraph (1) of this subsection, a hearing shall not be available to an individual by reason of such subparagraph (C) if the amount in controversy is less than $100; nor shall judicial review be available to an individual by reason of such subparagraph (C) if the amount in controversy is less than $1,000.

42 C.F.R. § 405.810 Review Determination

Subject to the provisions of §§405.807 through 405.809, the carrier shall review the claim in dispute and, upon the basis of the evidence of record, shall make a separate determination affirming or revising in whole or in part the findings and determination in question.

STATEMENT OF FACTS

Petitioner has operated Concourse Nursing Home ("Concourse"), a 240-bed skilled nursing home facility located in Bronx, New York since October, 1974. Travelers Insurance Company ("Travelers") was designated to act as a fiscal intermediary for the U.S. Department of Health and Human Services ("HHS") and was responsible for processing Concourse's Medicare claims.

Medicare program claims are divided into two parts: Part A for institutional costs and Part B for supplementary expenses. For the years 1976 through 1979 Concourse filed cost reports with Travelers. Travelers routinely denied almost all of Concourse's Part B claims. When Concourse attempted to appeal the denials, Travelers, in violation of 42 C.F.R. § 405.810, merely "shelved" the appeals applications, refusing to act upon them, thus thwarting any of Concourse's administrative remedies.

On or about December 6, 1979, Concourse commenced a suit against the Secretary of HHS and against Travelers, *Neiman v. Harris*, 79-C-3098 (E.D.N.Y.) (App. 244). Judge Charles P. Sifton rendered a decision onAugust 24, 1981 (App. 244-55) holding in part that Concourse's claim against Traveler's for its failure to review Concourse's appeals was not ripe and dismissed the claim without prejudice to renew after Concourse exhausted its administrative remedy before the Provider Reimbursement Review Board ("Board").

The Board refused to address the issue as beyond its jurisdiction. Moreover, the Board rejected petitioner's argument for an alternative remedy which would have involved applying "Method E" to settle Concourse's ancillary costs.

After the Board's decision in December of 1983, petitioner timely renewed his federal action against HHS and Travelers raising, *inter alia*, Travelers' failure to review Concourse's Part B denials. *Neiman v. Secretary et al.*, CV-83-5447. On September 17, 1988, Eastern District Judge Sifton issued a Memorandum and Order stating that the federal court did not have subject matter jurisdiction over this issue. The Second Circuit Court of Appeals affirmed in a Summary Order dated September 15, 1989. To date, Concourse has had no review of Traveler's refusal to review its Part B claims.

Jurisdiction Below

The District Court for the Eastern District of New York had jurisdiction under 28 U.S.C. §§1331(a), 1332, 1361, 2201, 2202 and 42 U.S.C. §1395ff.

ARGUMENT

An aggrieved Medicare recipient must be entitled to review of an egregious reimbursement determination. Moreover, if that right of review is denied, the party must be entitled to review of the alleged abuse. In the instant case, petitioner has been wholly deprived of a forum — either administrative or judicial — to review Travelers' willful and wanton refusal to review the denial of Concourse's Part B claims. Such denial of process violates the fundamental roots of our judicial system. U.S. Const., Amend. V; *Marbury v. Madison*, 5 U.S. 137, 163 (1 Cranch) (1803) (every right, when withheld must have a remedy).

This Court has explicitly recognized that the right of access to review should not be severed in the Medicare context, unless Congress unequivocally authorizes it:

> As a general matter, "[t]he mere fact that some acts are made reviewable should not suffice to support an implication of exclusion as to others. The right to review is too important to be excluded on such slender and indeterminate evidence of legislative intent."

Bowen v. Michigan Academy of Family Physicians, 476 U.S. 667, 674 (1986) (*citing*, *Abbott Laboratories v. Gardner*, 387 U.S. 136, 141 (1967)). Thus, the important right of review of Travelers' refusal to review cannot be denied in the absence of an explicit Congressional statement. Since no such statement has been made, the District Court and the Court of Appeals have improperly deprived petitioner of his right to review.

In the instant case, petitioner has repeatedly attempted to have Traveler's refusal to review the denial of its Part B claims reviewed in several forums: before Travelers, the Provider Reimbursement Review Board, the federal District Court and Court of Appeals. Each has declared the matter beyond its jurisdiction. Since Travelers refused to process the appeals, petitioner's administrative path was cut off. In effect, petitioner has been wholly deprived of any forum for review.

In fact, the lower courts herein incorrectly decided that they do not have jurisdiction over petitioner's sixth claim. Federal courts do have jurisdiction pursuant to 42 U.S.C. §1395ff over claims such as petitioner's sixth cause of action against federal actors under *Bivens v. Six Unknown Named Agents of the Federal Bureau on Narcotics*, 403 U.S. 388, 91 S. Ct. 1999, 29 L. Ed.2d 619 (1971).[1]

The District Court simply made a mechanical application of the apparent bright-line rule espoused in *Kuritzky v. Blue Shield of Western New York*, 850 F.2d 126 (2d Cir. 1988). *Kuritzky* set forth a ~~regulation~~/application dichotomy by which jurisdiction exists for challenges to Medicare regulations themselves but does not exist for challenges to *applications* of Medicare regulations. *See also, Michigan Academy, supra.* However, application of this methodology is not so clear cut. In the instant case, for example, Travelers inaction does not fit neatly into either category.

Moreover, the Court holdings in *Kuritzky* and *Michigan Academy* do not confine judicial review outside of 42 U.S.C. §§13955ff and 405(h) to challenges to rules or regulations.[2] Rather, *Michigan Academy* points out that "an attack on the validity of a regulation is not *the kind of* administrative action that we described in [*United States v. Erika*, 456 U.S. 201, 102 S.Ct. 1650, 72 L.Ed.2d 12 (1982)] as an 'amount determination'

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[1] It should be noted that a *Bivens* remedy is not barred by *Schweiker v. Chilicky*, __U.S.__, 108 S. Ct. 2460 (1988) (improper denial of disability benefits arising from due process violations did not give rise to claims for any damages against the government officials who administered the program). *Ysasi v. Rivkind*, 856 F.2d 1520 (D.C. Cir. 1988) held that *Chilicky* does not apply when utilization of the available statutory relief was "frustrated" by defendants. Concourse's whole claim against Travelers is that Travelers has frustrated Concourse's ability to obtain the review available to it pursuant to the Medicare statutory and regulatory scheme.

[2] In a very recent decision, the Second Circuit refused to address whether mandamus jurisdiction can be invoked to permit judicial review despite the apparently limiting language of 42 U.S.C. §405(h) because this Court has left the question open. *Anderson v. Bowen*, 881 F.2d 1, n. 11 (1989) *citing Heckler v. Ringer*, 466 U.S. 602, 616, 104 S.Ct. 2013, 2022, 80 L.Ed. 2d 622, 636-37 (1984). This is a closely related area ripe for Supreme Court review.

which decides 'the amount of the Medicare payment to be made on a particular claim' and with respect to which the Act impliedly denies judicial review." 476 U.S. at 676 (emphasis added).

The reason that an attack on the validity of a regulation is not "the kind of" administrative action for which review is denied is that the legality of a regulation is not considered in a "fair hearing" held by a carrier to resolve a grievance related to a determination of the amount of a Part B award:

> We conclude, therefore, that *those matters which Congress did not leave to be determined in a "fair hearing" conducted by the carrier* – including challenges to the validity of the Secretary's instructions and regulations – are not impliedly insulated from judicial review by 42 U.S.C. §1395ff.

Michigan Academy, 476 U.S. at 678 (emphasis added).

Thus, the test for whether §1395ff precludes jurisdiction is *not* merely whether the matter challenged is a regulation or the application of a regulation, but a broader one: *whether the matter is one that can be reviewed and determined in the administrative hearing process*. In the instant case, petitioner was unable to resolve its complaint in the administrative hearing process because Travelers refused to process petitioner's appeals. Thus, jurisdiction is viable under §1395ff.[3]

Some issues relating to the application of a regulation can be raised in an administrative hearing, such as whether calculations were properly made, and those issues must be raised within the confines of §1395ff. Other issues, however, which arguably can be called misapplications of regulations but which can not be challenged in an administrative hearing on an individual

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[3] Concourse alleged in its jurisdictional statement of the Complaint as an additional basis of jurisdiction, 28 U.S.C. §1332 (diversity jurisdiction). Upon information and belief Travelers is a corporation formed under the laws of Connecticut. It is undisputed that Travelers Insurance Company is a corporation with its main office for the transaction of business in Hartford, Connecticut. Therefore, there is a proper basis for diversity jurisdiction between Concourse and Travelers in a federal Court.

denial, such as Concourse's claims against Travelers' grand scheme of wholesale denials of claims, are free to proceed outside of §1395ff. Moreover, Travelers' actions *denied Concourse any administrative hearing* on Travelers' failure to properly process Concourse's Part B bills.

As discussed *supra*, the entire pattern of Travelers' conduct – the placing of Concourse's Part B bills on a shelf and not processing their applications further and denying Concourse the ability to appeal from the effective denials – and the federal and state law claims to which that pattern gives rise cannot be reviewed in a fair hearing. The determination of federal and state constitutional and statutory claims are not among the matters Congress delegated to carriers and intermediaries, and thus they are cognizable under *Michigan Academy*.

In fact, the Second Circuit in *Kuritzky*, *supra*, also enunciated that the key question is whether the claim was one "which Congress did *not* leave to be determined in a 'fair hearing' conducted by the carrier." (emphasis in original) *Michigan Academy*, 850 at 128.

This Court itself has recognized a distinction between misapplication of regulations in particular instances on the one hand and, on the other, pervasive schemes to deny massive amount of claims with impermissible motives. In *Bowen v. City of New York*, 476 U.S. 467, 106 S.Ct. 2022 (1986), a social security case, this Court distinguished "mere deviation from applicable regulations," and which did not "depend on the particular facts of the case before it; rather the policy was illegal precisely because it ignored those facts." *Id.* at 484, 106 S. Ct. at 2032. This Court thus waived the requirement of exhaustion of administrative remedies where the agency had adopted a secret administrative practice that imposed an undisclosed presumption upon the determination of eligibility for disability benefits.[4]

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[4] Significantly, the plaintiffs' claims in *Bowen v. City of New York*, *supra*, arose because the State and HCFA Regional Offices were acting contrary to regulations in processing disability claims in order to improve their performance reviews. *See*, *City of New York v. Heckler*, 578 F. Supp. 1109, 1118 (E.D.N.Y. 1984).

Because the Courts have evidenced a willingness to recognize a distinction between mere deviations from regulations and secret wholesale practices totally antithetical to regulations when the Government is the defendant, such a distinction should all the more readily be recognized when the action is against a private corporation that abused its position to enhance its own status with the Government.

This Court must grant certiorari to review the Court of Appeals decision which in effect wholly denied petitioner any forum for review of its issue which was properly within the federal Court's jurisdiction.

Respectfully submitted,

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APPENDIX

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK
x

MARVIN NEIMAN d/b/a Concourse Nursing Home,

Plaintiff, CV-83-5447

— against — MEMORANDUM AND ORDER

SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES OF THE UNITED STATES *et ano.*,

Defendants.
x

APPEARANCES:

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SIFTON, District Judge

Plaintiff, owner and operator of Concourse Nursing Home, commenced this action against the defendants Secretary of Health and Human Services (the "Secretary") and Travelers Insurance Company ("Travelers") challenging their decisions with regard to cost reimbursements due him under the Medicare Program, 42 U.S.C. §§1395 *et seq*. This matter is before the Court on defendants' motion to dismiss or alternatively for summary

judgment on plaintiff's sixth cause of action and on plaintiff's cross-motion for sanctions under Rule 11 and to correct discovery abuse.[1]

The Medicare Program, enacted to provide health insurance benefits to aged and disabled persons, is divided into two parts, Part A and Part B. Part A covers institutional health costs such as hospital expenses and is funded from Social Security taxes. 42 U.S.C. §1395c through i-2. Part B supplements Part A by insuring against a portion of some medical expenses not covered by Part A. It is originally funded by monthly payments paid by individuals who voluntarily enrolled, together with appropriations from the Treasury. *See United States v. Erika*, 456 U.S. 201 (1982); 42 U.S.C. §1395j, r, t and w. Congress has, since its enactment, amended the Medicare Act to provide that anyone who became eligible for Part B coverage would be enrolled automatically. 42 U.S.C. §1395p(f). The monies collected are deposited in the Federal Supplementary Medical Insurance Trust Fund that finances the Part B program. *Id.*

Generally, the Secretary administers the program, but the Secretary is authorized to assign the task of paying Part B claims from the Trust Fund to private insurance carriers. §1395u; *Erika, supra*, at 203. The recipients of Part B covered medical care may assign their claim to their medical providers. *Id.*

When the provider bills the private insurance carrier, the carrier determines whether the claim meets all of the Part B criteria. If the criteria are met, the carrier pays the claim out of federal funds. §1395u; *id.* If the carrier denies full reimbursement, the claimant may appeal. The first stage is a *de novo* review by a different carrier employee. The claimant who is still dissatisfied may petition for an oral hearing before a hearing officer designated by the carrier. *Erika, supra*; 42 U.S.C. §1395u(b)(3)(C); 42 C.F.R. §405.820. The decision of the hearing officer is final. *Erika, supra*, at 203.

Plaintiff's sixth cause of action[2] involves ancillary services provided to patients at the Concourse Nursing Home. Plaintiff alleges that certain speech and physical therapy services are

covered by Part B but that defendant Travelers, the insurance carrier, "intentionally, maliciously and wantonly refused to process plaintiff's Part B bills." Complaint, ¶65.

Defendants seek dismissal of the sixth cause of action on the grounds that (1) this Court lacks subject matter jurisdiction, (2) there has been no waiver of sovereign immunity for this kind of claim, (3) plaintiff has not exhausted his administrative remedies, (4) the court of claims has exclusive jurisdiction, (5) many of the claims are barred by the statute of limitations, (6) *res judicata* bars relitigation of certain claims decided previously in another action, and (7) Travelers is not a proper defendant.

DISCUSSION

Judicial review of Medicare claims is governed by 42 U.S.C. §1395ff. Under §1395ff(b)(2), as applicable at the time these claims arose, determinations of whether an individual is entitled to benefits under Part A or Part B and the determination of the amount of benefits under Part A are subject to judicial review.[3] *See* §1395ff(a). In *United States* v. *Erika*, *supra*, the Supreme Court reasoned from the language of §1395ff that judicial review of the amount of benefits awarded under Part A was available but that Congress deliberately foreclosed further review of Part B claims for reimbursement.

Subsequently, the Supreme Court explored the reach of its decision in *Erika*. In *Bowen* v. *Michigan Academy of Family Physicians*, 476 U.S. 667 (1986), the Court ruled that, although it barred review of determinations as to the amount of reimbursement, §1395ff did not bar review of the validity of the Secretary's regulations because the carrier would not be expected to review the validity of a regulation or rule in a fair hearing. Thus, as the Second Circuit recently explained in *Kuritsky* v. *Blue Shield of Western New York*, No. 88-6068, slip op. (June 27, 1988), "the distinction that emerges from *Erika* and *Michigan Academy* is that federal jurisdiction exists where there is a challenge to the validity of an agency rule or regulations, but jurisdiction is lacking where the claim is merely that the insurance carrier misapplied or misinterpreted valid rules and regulations." *Id.* at p.4552 (citations omitted).

It is not readily apparent from the wording of the complaint what the jurisdictional basis for plaintiff's sixth cause of action is. However, in plaintiff's papers in opposition to defendants' motion to dismiss, plaintiff suggests that the action is for recovery for defendant Travelers' *ultra vires* actions and for constitutional torts.[4] By failing to process plaintiff's Medicare applications as required by law, plaintiff contends, Travelers exceeded its statutory authority and violated plaintiff's fifth amendment and other statutory rights. In plaintiff's recent affidavit, he claims that, while certain bills were not processed at all, others that were processed were wrongfully denied by defendant "which then frustrated plaintiff's attempts to appeal such denials." Reply Affidavit, May 18, 1988.

Whether construed as a claim of *ultra vires* conduct or as a constitutional tort, this Court lacks subject matter jurisdiction.

Plaintiff cannot escape the reach of *Erika* by characterizing the action against Travelers as an "*ultra vires*" claim. This case is undistinguishable from *Kuritsky*, *supra*, in which judicial review was foreclosed for plaintiff's claim that "Blue Shield has failed to follow the provisions of both the regulations and the [Medical Carriers] Manual" in assessing the reimbursement owed to plaintiff. In that case, the Court of Appeals ruled that misapplication of valid regulations was not reviewable under *Erika*; and because plaintiffs did not attack the validity of any regulation or rule promulgated by the Secretary, the claim did not fall within the scope of *Michigan Academy*, *supra*.

Here, too, plaintiff does not seek to invalidate the methods by which carriers review and process claims. Rather, plaintiff believes that defendants failed to follow the proper procedures and thereby deprived him of amounts legally reimbursable. This is precisely the type of matter which is left to review by the carrier in a "fair hearing" conducted pursuant to §1395u(b)(3)(C), *see Michigan Academy*, *supra*, 476 U.S. at 678, and which is precluded from review by *Erika*, *supra*.[5]

Nor can plaintiff assert jurisdiction by characterizing his action as an action to recover for the constitutional tort of federal

officials under *Bivens v. Six Unknown Federal Narcotics Agents*, 403 U.S. 388 (1971). In *Bivens*, the Court provided a remedy for money damages where a federal officer deprived an individual of his fourth amendment rights. The Court subsequently extended the cause of action to violations of the due process clause of the fifth amendment, *Davis v. Passman*, 442 U.S. 228 (1979), and the cruel and unusual punishment clause of the eighth amendment, *Carlson v. Green*, 446 U.S. 14 (1980). However, in all of these cases, the Court found no "special factors counselling hesitation in the absence of affirmative action by Congress." *Davis*, *supra*, at 246-47.

In recent cases, however, *Bivens* has not been extended to provide a private cause of action where Congress has created a comprehensive statutory scheme that does not include such an action. According to the Supreme Court, the issue "is whether an elaborate remedial system that has been construed step by step, with careful attention to conflicting policy considerations, should be augmented by the creation of a new judicial remedy for the constitutional violation at issue." *Bush v. Lucas*, 462 U.S. 367, 388 (1983). In *Bush*, the Court refused to create a *Bivens* remedy where a discharged federal employee claimed a first amendment violation. The Court reasoned that, since "the employment relationship is governed by comprehensive procedural and substantive provisions," 462 U.S. at 368, the judiciary should defer the decision of Congress not to provide a *Bivens* cause of action. *Id.*, at 389.

Most recently, in *Schweiker v. Chilicky*, 108 S.Ct. 2460, 56 U.S.L.W. 4767 (June 24, 1988), the Court refused to create a *Bivens* remedy for individuals alleging due process violations by administrators of the "continuing disability review" (CDR) program in the termination of their disability benefits. The Court noted that the system established by Congress for the protection of the rights of those terminated was "considerably more elaborate than the civil service system considered in *Bush*." Consequently, the conclusion of *Bush* that "Congress is in a better position to decide whether or not the public interest would be served" by creating a new substantive legal liability," *quoting*

826 U.S. at 390, is equally applicable, if not more, in the CDR context.

The holdings in *Bush* and *Chilicky* are controlling in this case because Congress had similarly created an elaborate and comprehensive scheme for health care providers to receive reimbursement for services performed as well as a system of appeal within the administrative framework. As described earlier, a claimant or his health care provider submits a claim to the insurance carrier for determination of whether the claim is covered and how much reimbursement is due. If approved, the carrier sends the claimant an "Explanation of Medicare Benefits" form, together with payment. 42 C.F.R. §405.803. A claimant may request a review of the determination, which is then carried out by a different employee of the carrier. 42 C.F.R. §405.807, 405.810. After review, the carrier must send the beneficiary a notification of the basis of the determination. 42 C.F.R. §405.811. When the amount in controversy is $100 or more, the carrier is required to provide an opportunity for a fair hearing. 42 U.S.C. §1395u(b)(3)(C). A hearing officer, an employee of the carrier conducts the hearing, and the decision of the hearing officer is final. 42 U.S.C. §1395ff. The holding in *Erika* makes clear that "the hearing officer is the final arbiter of Part B benefit amount disputes based on the carrier's application or interpretation of agency rules and regulations." *Kuritsky, supra.*

The careful consideration given by Congress to the Medicare statute and particularly its judicial review provisions strongly suggests that Congress has provided all the remedies it finds necessary for the problems created by carriers' failure to reimburse Medicare beneficiaries adequately. As emphasized in *Chilicky*, "Congress is the body charged with making the inevitable compromises required in the design of a massive and complex welfare benefits program." Slip op. at 16. As such, a *Bivens* remedy is not available.

Accordingly, plaintiff's sixth cause of action must be dismissed.

Plaintiff seeks Rule 11 sanctions for defendants' frivolous motion. Since defendants' arguments are meritorious, sanctions are clearly inappropriate.

For the reasons stated above, defendants' motion to dismiss plaintiff's sixth cause of action is granted.

The Clerk is directed to enter judgment dismissing the complaint in its entirety in accordance with this decision and that being filed simultaneously on plaintiff's fifth cause of action and to mail a copy of the within to all parties.

SO ORDERED.

Dated : Brooklyn, New York
September 17, 1988

United States District Judge

FOOTNOTES

1 Plaintiff has also moved for summary judgment on the fifth cause of action. A separate set of papers have been submitted on that issue and is the subject of a separate Memorandum and Order, which is being filed simultaneously herewith. Defendant does not dispute the Court's jurisdiction to review the Secretary's decisions on the claims raised in plaintiff's fifth cause of action.

2 The parties have stipulated to the dismissal of the first, second and fourth claims of plaintiff's complaint. In addition, the parties have agreed to merge the third claim with plaintiff's fifth claim.

3 In 1986, §1395ff(a) was amended to provide for review of the determination of the amount of benefits under Part A and Part B. However, §9341 of Pub. L. 99-509 provided that the amendment apply to items of services furnished on or after January 1, 1987. The instant case involves claims from 1976 through 1979.

4 Plaintiff insists that Travelers rather than the Secretary is the true party defendant in this case, presumably to avoid the reach of sovereign immunity. Nevertheless, the fiscal intermediaries who administer the Medicare Act are agents of the Secretary and their actions are legally imputable to the Secretary. *See Fox v. Bowen*, 656 F. Supp. 1236, 1238 n.3 (D. Conn. 1987); *Kraemer v. Heckler*, 737 F.2d 214 (2d Cir. 1984).

5 Both cases cited by plaintiff in his most recent submission to the Court, a letter dated July 21, 1988, provide review in the district court where the legality of the regulations are challenged. *Bethesda Naval Hospital Assoc. v. Bowen*, 108 S. Ct. 1255 (1988); *Integrated Generics v. Bowen*, 678 F. Supp. 1004 (E.D.N.Y. 1988). Plaintiff argues that these cases suggest a broad range of review by the district court. Such is not the case.

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK x

MARVIN NEIMAN d/b/a Concourse Nursing Home,

Plaintiff, CV-83-5447

– against – MEMORANDUM AND ORDER

SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES OF THE UNITED STATES *et ano.*,

Defendants.

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APPEARANCES:

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Counsel for Defendants

SIFTON, District Judge

Plaintiff, a nursing home operator, commenced this action seeking review of an administrative decision relating to the amount of Medicare reimbursement due plaintiff for fiscal years ended December 31, 1976, through December 31, 1979. This Court has jurisdiction over the action based upon 42 U.S.C. §1395oo(f).

This matter is presently before the Court on plaintiff's motion for partial summary judgment pursuant to Rule 56 of the Federal Rules of Civil Procedure and defendants' cross-motion for partial judgment on the pleadings pursuant to Rule 12(c) of the Federal Rules of Civil Procedure.

The statutory background of this lawsuit is set forth in this Court's opinion granting defendants' motion for summary judgment with respect to plaintiff's sixth cause of action, which is being filed simultaneously with this decision.

Plaintiff's motion and defendants' cross-motion raise three issues: (1) whether plaintiff's drug storage space should be considered an ancillary cost center, (2) whether Part B ancillary costs should be apportioned by "Method E" PRM-1 (Provider Reimbursement Manual) §2208.3(E), or by "Method A" PRM-1 §2208.3(A), and (3) whether the salaries of employees assigned to transport patients from routine care areas to the physical, speech, and occupational therapy areas can properly be considered an ancillary cost.

The following facts are derived from the testimony and exhibits offered at the administrative hearing. Plaintiff is a 240-bed skilled nursing facility and provides services to both Medicare and non-Medicare patients. In return for providing services to Medicare beneficiaries, plaintiff is reimbursed by the Department of Health and Human Services ("HHS") for the "reasonable cost" of furnishing these services. 42 U.S.C. §1395x(v)(1)(A). HHS defines "reasonable cost" as costs actually incurred, excluding unnecessary costs.

HHS enters into agreements with various insurance companies to process Medicare program claims received from care providers such as plaintiff. 42 U.S.C. §1395h. In the present case, Travelers Insurance Company served as the intermediary and is also named in this action as a defendant. These intermediaries review the providers' claims and annual reports and make determinations of the total cost HHS will recognize as a "reimbursable" Medicare cost reimbursement. However, as is the case here, when a provider is unsatisfied with the intermediary's determination,

it may request an administrative hearing before the Provider Reimbursement Review Board (the "Board"). 42 U.S.C. §1395oo(a). Decisions of the Board constitute the Secretary's final decision, unless within sixty days of the provider receiving notice of the Board's decision the Secretary reverses, affirms, or modifies the Board's decision on his own. 42 U.S.C. §1395oo(f)(1).

The determination in question is for claims filed with Travelers for the years 1976 through 1979. Plaintiff questions both Travelers' determination and the Board's subsequent affirmance of that determination[1] of the reasonable costs incurred for both routine services (bed, board, nursing care, and minor medical and surgical supplies) and ancillary services (*inter alia*, physical, speech and occupational therapy, and prescription drugs).

Under the Medicare statute, a storage space for prescription drugs may be considered an ancillary cost. 42 U.S.C. §1395x(v)(1)(A), 42 C.F.R. §404.453(d)(1). Plaintiff unsuccessfully argued at the administrative hearing that Travelers improperly determined that costs of the prescription drug storage space for the years 1976 through 1979 were routine service costs.

This determination decreased plaintiff's reimbursement because Medicare beneficiaryies' utilization of services associated with ancillary costs is significantly higher than their utilization of services associated with routine costs. As a result, if the cost of maintaining the room is regarded as an ancillary cost, a higher reimbursement rate will apply.

Plaintiff offered no documentation indicating whether the drugs stored in the room were prescription or non-prescription. However, plaintiff claims that the storage space was developed pursuant to a regulation of the New York State Department of Health which requires a room for the storage and safeguarding of drugs. Plaintiff's witness, Dr. Leon Singer, Concourse's medical director, stated that 75% of the 5'-by-6' space was used for the storage and protection of prescription drugs, including narcotics and tranquilizers. The remaining 25%, he claimed, was used for non-prescription drugs and "a small amount" of surgical items for the nurses' and doctors' convenience.

Plaintiff also unsuccessfully disputed Travelers' use of Method A for determining plaintiff's 1976 through 1978 Part B ancillary costs. Part A of the Medicare program covers institutional health costs such as inpatient hospital care, extended care services, home health services, and hospice care. 42 U.S.C. §§1395c through 1395i-2. Part B supplements Part A's coverage by insuring against medical expenses such as physician services, therapy, and diagnostic tests. 42 U.S.C. §§1395j through 1395w. Method A calculates costs with the following equation: (Medicare/Total Charges) X (Total Ancillary Costs). Plaintiff claims that the figures that were inserted into the equation were too low because Travelers improperly refused to process certain Part B Medicare bills (the subject of plaintiff's sixth claim), thus decreasing the numerator. Plaintiff also claims that Travelers' determination that the drug storage space and the salaries of certain transporters were routine costs improperly decreased "total ancillary costs."

Plaintiff contends that Method E should have been used. Method E is calculated as follows: (2.5/100) X (98/100) X (average per diem routine and ancillary service costs) X (Medicare Part B inpatient days). Had Method E been used, plaintiff claims that it would have received $585,161 more in reimbursement.

Plaintiff also disputes Travelers' determination that the salaries of certain nursing aides and the costs of their supervision from 1977 through 1979 were routine and not ancillary costs.

As part of its program to provide rehabilitative therapy for its patients, plaintiff trains its nursing aides in basic rehabilitative therapy such as the correct way to exercise the patients. As part of this training, nursing aides work with the physical and occupational therapy departments (ancillary departments) as transporters and therapists' assistants for six weeks. Each department is assigned one transporter and one assistant. Therefore, at any given time, a total of four nursing aides worked for these departments. After the six-week period ends, each nursing aide returns to his or her general duties in a routine service area, and another nursing aide takes the place of the trained aide for a six-week rotation.

The transporter transports the patients from their rooms to the therapy departments. Once in the therapy department, the transporter watches over and helps the therapist lift and move the patient. The therapy assistant furnishes any necessary assistance to the therapist but, unlike the transporter, does not transport the patient in and out of the department.

During the six weeks, the nursing aides continue to punch their nursing department time cards. Likewise, their progress is monitored by, and any discipline is meted out through, the nursing department.

The plaintiff, in its cost reports, allocated the salaries of these aides to the therapy departments, rather than the nursing department. Plaintiff introduced payroll documentation to demonstrate that the aides were employed. However, plaintiff did not provide documentation with regard to which nurses' aides worked for the therapy departments in any given six-week period, what they did, and how many hours a day they performed ancillary work.

The Board determined that the aides' salaries were routine service costs because of lack of documentation, a presumption that transportation is a routine service, and the fact that the aides were permanent employees of the nursing department, a routine cost center. The Board also reversed a previous 1977 determination by Travelers that these aides performed ancillary services.

DISCUSSION

In determining reasonable costs, the Board's decision may be reversed only if it is arbitrary, capricious, not supported by substantial evidence or otherwise not in accordance with the law. 5 U.S.C. §706(2)(a); *St. Mary's Hospital v. Blue Cross & Blue Shield Ass'n*, 788 F.2d 888, 890 (2d Cir. 1986); *Friedman v. Heckler*, 765 F.2d 383, 384 (2d Cir. 1985). The construction and application of a statute by the agency charged with its adminstration is entitled substantial deference unless it is inconsistent with the terms of the regulation itself. *Friedman v.*

Heckler, supra, 765 F.2d at 386; *Grocery Manufacturers of America, Inc. v. Gerace*, 755 F.2d 993, 1001 (2d Cir. 1985). Thus, the Provider Reimbursement Manual, although merely a manual interpreting the Medicare statute and not a regulation in itself, is entitled to be given weight. However, the manual is without force of law. *St. Mary's Hospital, supra*, at 890.

This Court must review the whole record or those parts of it cited by the parties in making a determination. 5 U.S.C. §706. The review, however, is confined to the decision of the agency and the evidence on which it was based. *De nove* review of questions of fact is authorized only when the agency's factfinding procedures are inadequate or when issues that were not before the agency are raised in a proceeding to enforce non-adjudicatory agency action. *Citizens to Preserve Overton Park, Inc. v. Volpe*, 401 U.S. 402, 415 (1971). Neither of these two situations exist here.

Plaintiff's contention disputing the Board's determination that certain drug storage space was a routine cost center lacks merit. The Board found that, due to lack of documentation, plaintiff had failed to demonstrate that the primary function of the room was to store prescription drugs.

Costs of non-revenue producing cost centers are allocated to the revenue-producing centers which they serve. 42 C.F.R. §405.453(d)(1). Indirect costs of services are considered in the reimbursement calculation. 42 U.S.C. §1395x(v)(1)(A). A prescription drug storage room is an indirect cost of providing prescription drugs to individual patients – an ancillary service. Thus, a prescription drug storage room is considered an ancillary cost.

Dr. Singer testified for plaintiff that approximately 75% of the storage room was used for prescription drugs. The Board did not find Dr. Singer's testimony incredible. Although Dr. Singer was an interested witness, there was in fact little reason to question his credibility or veracity. Had he testified untruthfully, it is doubtful that he would have characterized the room as being partially (25%) filled with non-prescription drugs and medical supplies. Such a characterization decreased plaintiff's

reimbursement. Dr. Singer's testimony regarding the nursing aides' workday during their six-week therapy rotation is equally indicative of his honesty. He was unwilling to account for the transporters' and therapy assistants' whereabouts beyond the hours that he himself was working in the buiding. Thus, since he arrived at work two hours after the nursing aides did, he was unwilling to testify to their whereabouts during these two hours, even though he assumed they were working in their respective therapy departments. Once again, this testimony decreased plaintiff's recovery. Dr. Singer's testimony that 75% of the space was used to store prescription drugs went uncontradicted. Nevertheless, the Board refused to classify the room as used for prescription drug storage based on an absence of adequate documentation to support it.

Providers receiving reimbursement must provide adequate cost data. Costs must be demonstrated by financial and statistical records which are capable of verification by qualified auditors. 5 U.S.C. §405.453. Defendants argue that, because plaintiff did not provide any verifiable documentation demonstrating that the room was utilized for the storage of prescription drugs, plaintiff has not provided adequate cost data and, thus, has lost its right to the reimbursement it seeks.

Defendants cite *Davies County Hospital v. Bowen*, 811 F.2d 338 (7th Cir. 1987), to demonstrate the degree of weight afforded to the documentation provisions of the Medicare statute and the Provider Reimbursement Manual. In that case, the Seventh Circuit reversed a district court's judgment that, despite poor records, the provider could receive reimbursement for therapy services. The Seventh Circuit's decision found that adequate documentation was a prerequisite to recovery. As in *Davies County Hospital*, the matters in question were easily documentable. In *Davies*, the manual sets forth specific requirements for documentation for therapy services, including a daily log. PRM-1 §1417(A). Moreover, the plaintiff had previously been warned by the intermediary that it had not been complying with the recordkeeping requirements of the manual. In the present case, it was not unreasonable for defendant to conclude that records of the sort necessary to assure the security of narcotic and

prescription drugs should have been kept and made available to the Secretary's representatives to back up the otherwise vague testimony of Dr. Singer that "75%" of the space in the room was used for stogage of such drugs. Thus, quite apart from the demands of the Secretary for documentation subject to audit to back up *any claim* for reimbursement, the Secretary was clearly reasonable in asking for documentation of the sort required to be maintained in the ordinary course of the hospital's business to ensure that its stock of narcotic and prescription drugs were not subject to pilferage and loss.

Plaintiff's assertion that Part B ancillary costs should have been calculated by using Method E must also fail. In *Feldman v. Heckler*, 765 F.2d 383, 388 (2d Cir. 1985), the Court of Appeals for this Circuit held that Method E is designed for use by a skilled nursing home that has an all-inclusive rate and cannot be used by a facility that has a charge structure for individual services rendered. *See* PRM-1 §2208.2. Accordingly, plaintiff's claim that Travelers should have calculated physical therapy (ancillary) costs by Method E must be rejected since the record makes clear that plaintiff was a skilled nursing facility with a charge structure, charging separately for ancillary services. Thus, plaintiff is not entitled to use Method E.

Plaintiff seeks to avoid the application of *Feldman* by relying on PRM-1 §2208.3, which states:

> "[T]he procedures outlined in this section [Methods A through E] have not been specifically directed towards the all-inclusive rate and no-charge structure hospital-skilled nursing facility complex."

In *Franklin Nursing Home v. Blue Cross Blue Shield*, CCH Medicare and Medicaid Guide ¶3,637, PRRB Hearing Dec. Nov. 7, 1983, the Board adopted the §2208.3 approach.

However, for PRM-1 §2208.3 to be applicable, the provider must be a skilled nursing facility complex. *Feldman, supra*, at 388, PRM-1 §2208.3. Just as plaintiff's nursing home in *Feldman*, a 205-bed skilled nursing facility is not a "complex,"

and therefore plaintiff cannot use PRM-1 §2208.3 for access to Method E.

Finally, plaintiff disputes Travelers' determination that the salaries of the short-term therapy assistants and transporters are routine costs. These aides, plaintiff claims, provided essential services to the therapy department. Had the nurses' aides not rotated for six weeks in these departments, plaintiff argues that permanent transporters and therapy assistants would have been hired and the expense of their salaries reimbursed as ancillary costs.

As already noted, the Medicare program requires that care providers provide verifiable cost data in order to receive reimbursement. 42 C.F.R. §405.453(a). This requirement applies to the salaries of transporters, *St. Margaret's Hospital v. Blue Cross Ass'n*, CCH Medicare and Medicaid Guide ¶32,246, HCFA Admn. Dec., Sept. 20, 1982, and therapy assistants.

Plaintiff claims that, although the transporters and assistants were paid, monitored, and supervised by the nursing department, they worked for the therapy departments. However, plaintiff has provided no documentation or records detailing who the rotating transporters and assistants were and when they worked in the ancillary departments. Since these nurses' aides continued to punch their nursing department time cards, plaintiff's records reflect that the nurses' aides were employed by the nursing department during the period of time in question. As for their actual functions, plaintiff relied on the testimony of Marvin Neiman, the owner and operator of Concourse Nursing Home, and Dr. Singer. Neither witness' testimony went beyond generalizations about the existence of this educational rotation program; and, unlike the case with the prescription drugs issue, there is no record anywhere that these nurses were needed and used by the hospital in the way in which the witnesses described.

The lack of this basic information precludes the allocation of the nursing aides' salaries to an ancillary cost center. However, because the records do demonstrate that nursing aides were

employed by the nursing department, the salaries can be allocated to a routine cost center in accordance with 42 C.F.R. §405.453.

Even if there had been adequate cost data, the transporters' salaries still may not have been appropriately allocated to an ancillary cost center.[3] Transportation may be considered a routine service even when it involves special care for particular handicaps. For example, particularized nursing services such as handfeeding and incontinency care are considered routine. PRM-1 §2203.1(A). Administrative decisions are inconsistent as to whether transporter costs are routine or ancillary. *See Community Hospital of Indianapolis, Inc. v. Blue Cross and Blue Shield*, CCH Medicare and Medicaid Guide ¶33,561, PRRB Dec. No. 83-D150, Dec. 7, 1983; *Sisters of Charity Hospital v. Blue Cross Ass'n*, CCH Medicare and Medicaid Guide ¶31,073 PRRB Dec. No. 81-D50, *but see St. Margaret's, supra*, and *Mercy Hospital Association v. Blue Cross Ass'n*, CCH Medicare and Medicaid Guide ¶32,048, HCFA Admn. Dec., May 28, 1982.

The transporters' chief function was to transport patients from a routine area to an ancillary area (therapy department). No evidence indicated that, once in the therapy department, they did anything beyond minor lifting (e.g., helping the patient stand) and observing the patient – chores that could have been handled by either therapy or nursing assistants. Transporting a patient from a routine department to an ancillary department is not necessarily an ancillary service. *Community Hospital of Indianapolis, supra*; *Sisters of Charity Hospital, supra*. Just as certain patients need help eating, a routine services under PRM-1 §2203.1(A), others need help walking. Some patients need transportation to the cafeteria, others to the recreation room, and still others to the therapy department. Unlike a service provided only to those patients undergoing therapy, all patients in need of assistance receive a transporter's assistance. Transportation is, thus, most easily seen as a routine and generalized service provided by any skilled nursing home. In either event, the salaries of these nurses' aides were properly allocated to the nursing department.

For the reasons set forth above, defendants' motion for judgment on the pleadings in its favor with respect to plaintiff's fifth claim is granted.

The Clerk is directed to mail a copy of the within to all parties.

SO ORDERED.

Dated : Brooklyn, New York
September 17, 1988

/s/
United States District Judge

FOOTNOTES

1 The Secretary declined to review further the Board's decision.

2 Plaintiff cites HIM-13 §4116, 4116.1 (a manual similar to the Providers' Reimbursement Manual) to back up its contention that onsite observation would have been the most appropriate form of verification in this situation. A floor plan of the provider's facility, according to §4116.1, must be "tested during an audit or during an intermediary onsite visit." However, this section applies to a "permanent reference file" that an intermediary must keep on each provider. It does not refer to the documentation or records necessary to receive reimbursement.

3 Under PRM-1 §§2220.1, therapy assistants' salaries may, when certain conditions are met, be allocated to an ancillary cost center. However, the provisions of 42 C.F.R. §405.453 must still be met.

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK

MARVIN NEIMAN d/b/a Concourse Nursing Home,

Plaintiff,

JUDGMENT

CV-83-5447 (CPS)

—against—

SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES OF THE UNITED STATES, et ano.,

Defendants.

Memoranda and orders of Honorable Charles P. Sifton, United States District Judge, having been filed on September 21, 1988 granting defendants' motion for judgment on the pleadings in favor of defendant with respect to plaintiff's fifth claim, granting defendants' motion to dismiss plaintiff's sixth cause of action, denying plaintiff's cross-motion for Rule 11 sanction against defendants, and directing judgment be entered dismissing the complaint in its entirety, its is

ORDERED and ADJUDGED that plaintiff take nothing of defendants; that defendants' motion for judgment on the pleadings in favor of defendant with respect to plaintiff's fifth claim is granted; the defendants' motion to dismiss plaintiff's sixth cause of action is granted; that plaintiff's cross-motion for Rule 11 sanctions against defendants is denied; and that judgment is hereby entered dismissing the complaint in its entirety.

Dated: Brooklyn, New York
February 3, 1989

/s/ Robert C. Heinemann
ROBERT C. HEINEMANN
Clerk of Court

UNITED STATES COURT OF APPEALS

FOR THE SECOND CIRCUIT

At a stated term of the United States Court of Appeals for the Second Circuit, held at the United States Courthouse in the City of New York, on the 15th day of September, one thousand nine hundred and eighty-nine.

Present:

Honorable Ralph K. Winter,
Honorable Roger J. Miner,
Honorable Frank X. Altimari,
Circuit Judges.

MARVIN NIEMAN d/b/a CONCOURSE NURSING HOME,
Plaintiff-Appellant,

v.

ORDER
No. 89-6075

MARGARET M. HECKLER, SECRETARY OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, and THE TRAVELERS INSURANCE COMPANIES,
Defendants-Appellees.

Appeal from the United States District Court for the Eastern District of New York.

This cause came on to be heard on the transcript of record from the United States District Court for the Eastern District of New York, and was argued by counsel.

ON CONSIDERATION WHEREOF, it is now hereby ordered, adjudged, and decreed that the judgment of said District Court be and it hereby is affirmed.

We affirm for substantially the reasons stated by the district court.

/s/ Ralph K. Winter

HON. RALPH K. WINTER, U.S.C.J.

/s/ Roger J. Miner

HON. ROGER J. MINER, U.S.C.J.

/s/ Frank X. Altimari

HON. FRANK X. ALTIMARI, U.S.C.J.

N.B. *This summary order will not be published in the Federal Reporter and should not be cited or otherwise relied upon in unrelated cases before this or any other court.*

No. 89-811

In the Supreme Court of the United States

OCTOBER TERM, 1989

MARVIN NEIMAN, d/b/a/ CONCOURSE NURSING HOME, PETITIONER

v.

LOUIS W. SULLIVAN, SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF FOR THE FEDERAL RESPONDENT IN OPPOSITION

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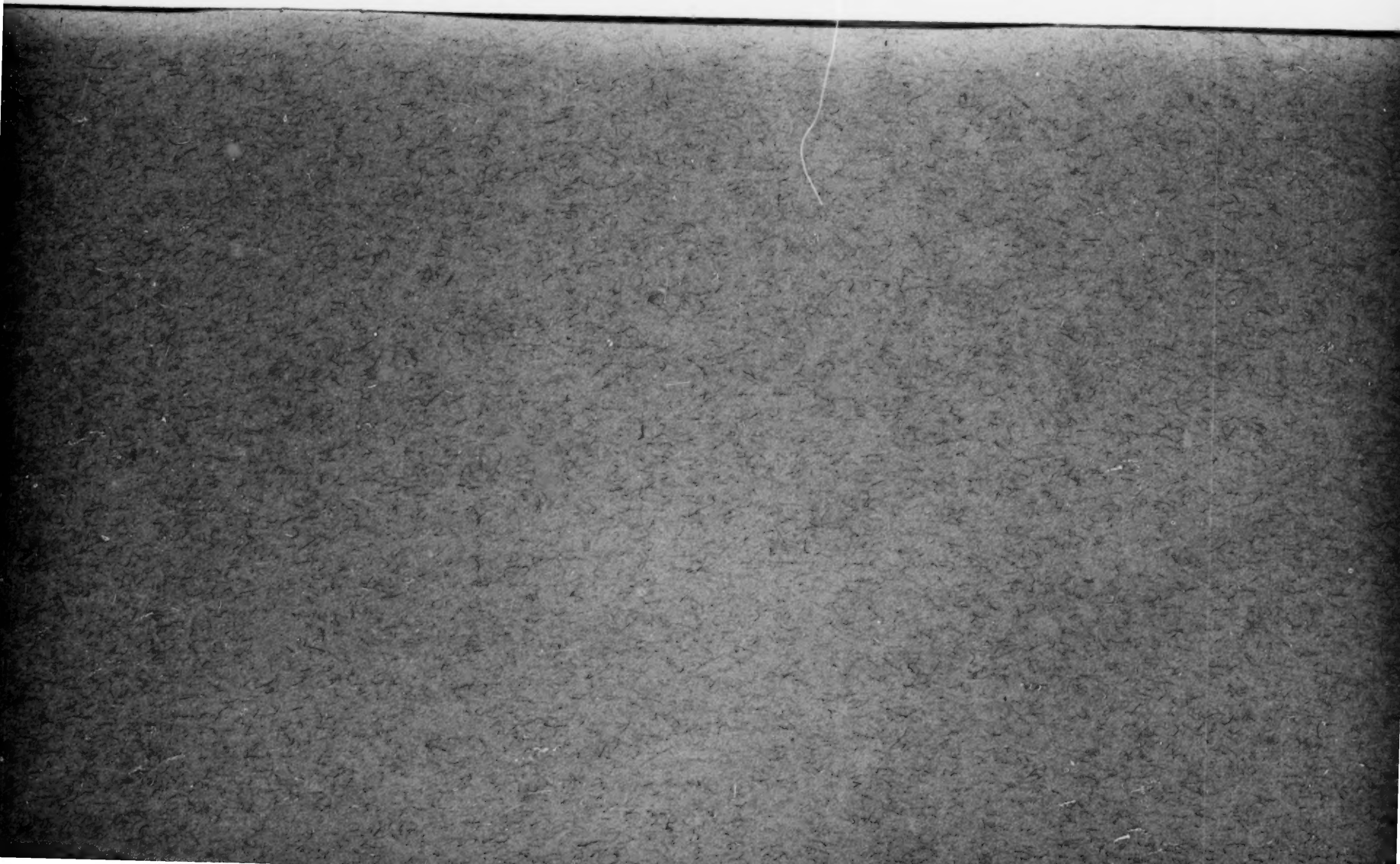

QUESTION PRESENTED

Whether the district court erred in holding that it lacked jurisdiction to consider petitioner's allegation that the Medicare fiscal intermediary improperly failed to consider petitioner's claims for reimbursement under Part B of the Medicare Act.

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BRIEF FOR THE FEDERAL RESPONDENT IN OPPOSITION

OPINIONS BELOW

The decision of the court of appeals (Pet. App. A22-A23) is unpublished, but the decision is noted at 888 F.2d 126 (table). The orders of the district court (Pet. App. A1-A8, A9-A20) are reported at 722 F. Supp. 950 and 722 F. Supp. 954.

JURISDICTION

The judgment of the court of appeals was entered on September 15, 1989. The petition for a writ of certiorari was filed on November 15, 1989. This Court has jurisdiction under 28 U.S.C. 1254(1).

STATEMENT

1. Medicare Part B is a voluntary supplemental insurance program that provides reimbursement for certain physician and related ancillary services. 42 U.S.C. 1395k (1982 & Supp. V 1987). Private insurance carriers administer Part B benefits under contracts with the Secretary of Health and Human Services (HHS). 42 U.S.C. 1395u(a)(1); *United States* v. *Erika, Inc.*, 456 U.S. 201, 202-204 (1982); *Bowen* v. *Michigan Academy of Family Physicians*, 476 U.S. 667, 674-675 (1986). The carrier reimburses Medicare patients, or their providers as assignees, for 80% of the "reasonable charges" for services as determined by the carrier in accordance with the Medicare statute and regulations promulgated by the Secretary. 42 U.S.C. 1395j-1395w (1982 & Supp. V 1987).

In order to be eligible for payment, either the beneficiary or the institution that provided the medical services to the beneficiary (the provider) must submit a timely claim to the carrier. 42 C.F.R. 405.250 (1986). Providers must furnish all necessary information to the carrier to allow the carrier to determine reimbursement. 42 C.F.R. 405.252(a) (1986). If the carrier denies a claim, the provider may request review from the carrier within six months of the denial. 42 C.F.R. 405.807, 405.810. See *Erika*, 456 U.S. at 203. If the carrier denies the claim after this review, the provider may within six months request an oral hearing if the amount in con-

troversy exceeds $100. 42 C.F.R. 405.820. See *Erika*, 456 U.S. at 203. In addition, if the carrier fails to act on an initial claim within 60 days of its receipt, the provider may request initial determination of the claim at an oral hearing. 42 C.F.R. 405.801 (a) and (b), 405.803(a), 405.820(d). During the time period relevant to this dispute, the Act did not provide for administrative review by the Secretary or for judicial review of the carrier's final determination whether a particular claim was covered by Part B or of the amount of reimbursement due under Part B. 42 U.S.C. 1395ff, 1395ii; *Erika*, 456 U.S. at 206-211.[1]

2. Petitioner is the sole owner and operator of a skilled nursing facility. Respondent Travelers Insurance Company acted as the carrier for petitioner's Medicare claims. Pet. App. A1. For the years 1976 to 1979, petitioner submitted to the carrier a number of claims for Medicare reimbursement under both Parts A and B. *Id.* at A9. In count six of his complaint (the only claim on which petitioner seeks review in this Court), petitioner alleged that the carrier "intentionally, maliciously, and wantonly" refused to process 2200 bills submitted by petitioner for reimbursement under Part B for physical and speech therapy services provided to over four hundred patients in petitioner's nursing facility (Pet.

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[1] In 1986, Congress amended 42 U.S.C. 1395ff(b) (Supp. V 1987) to permit judicial review of Part B benefit amount determinations where the amount in controversy is $1000 or more. Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509, Tit. IX, § 9341(a), 100 Stat. 2037-2038. However, those amendments apply only to services furnished on or after January 1, 1987. § 9341(b), 100 Stat. 2038. Because the services at issue in the instant case were rendered prior to that date, the 1986 amendments do not apply here.

App. A2-A3; Gov't C.A. Br. 17). The Secretary, on behalf of himself and the carrier, responded to these allegations, *inter alia*, by arguing that, in accordance with this Court's decision in *Erika*, the district court lacked jurisdiction to review these claims. Gov't C.A. Br. 20-27. With regard to the 2200 bills allegedly not processed, the Secretary also asserted, based on the documentation that petitioner provided, that the allegations were frivolous on their face. The Secretary pointed to evidence that the carrier had reviewed and either approved or denied bills submitted on 343 patients, and had determined that another set of bills lacked the proper documentation needed for processing. With regard to the remaining group of allegedly unprocessed bills representing claims on 33 patients, the Secretary explained that petitioner had failed to exhaust administrative remedies in that he had not requested a hearing within 60 days of submission of the bills to complain of failure to process. See Gov't C.A. Br. at 17-19. See also p.3, *supra* (regulations governing appeals to carrier for failure to process claims).

3. The district court dismissed count six for lack of jurisdiction (Pet. App. A1-A8). The court relied on the distinction recognized by this Court in *United States* v. *Erika*, *supra*, and *Bowen* v. *Michigan Academy*, *supra*, between a claim "merely that the insurance carrier misapplied or misinterpreted valid rules and regulations," which is unreviewable, and "a challenge to the validity of an agency rule or regulations," over which federal courts have jurisdiction. Pet. App. A3 (quoting *Kuritzky* v. *Blue Shield of Western New York, Inc.*, 850 F.2d 126, 128 (2d Cir. 1988), cert. denied, 109 S. Ct. 787 (1989)). The court concluded that petitioner "cannot escape the

reach of *Erika* by characterizing the action against Travelers as an '*ultra vires*' claim." *Ibid.* It observed that petitioner was not seeking "to invalidate the methods by which carriers review and process claims," Pet. App. A4, "but had alleged only that the carrier "failed to follow the proper procedures and thereby deprived him of amounts legally reimbursable." *Ibid.* The court concluded that "[t]his is precisely the type of matter which is left to review by the carrier in a 'fair hearing' conducted pursuant to § 1395u(b)(3)(C), *see Michigan Academy, supra*, 476 U.S. at 678, and which is precluded from review by *Erika, supra*." Pet. App. A4.

The court also rejected petitioner's theory that, by allegedly denying him due process of law, the carrier's actions could be challenged as a constitutional tort under *Bivens* v. *Six Unknown Named Agents of Federal Bureau of Narcotics*, 403 U.S. 388 (1971). The district court relied on *Schweiker* v. *Chilicky*, 108 S. Ct. 2460 (1988), in which this Court held that no *Bivens* remedy was available for actions based on claims for benefits under the social security disability program, because Congress has already created an elaborate system for review of those claims. The district court concluded that a *Bivens* remedy likewise is unavailable here, where "Congress ha[s] similarly created an elaborate and comprehensive scheme for health care providers" to obtain review of claims for reimbursement under Part B. Pet. App. A6. The court of appeals affirmed without an opinion, "for substantially the reasons stated by the district court" (Pet. App. A23).

ARGUMENT

The unpublished order of the court of appeals affirming the decision of the district court correctly applies this Court's rulings regarding review of Medicare Part B claims and does not conflict with any decision of another court of appeals. The issue presented here is also of little continuing importance in light of Congress's intervening amendment of 42 U.S.C. 1395ff to permit judicial review of benefit amount determinations under Part B of Medicare. This Court has recently denied review in three other cases raising similar issues of the reviewability of Part B claims, see *Texas Medical Ass'n* v. *Sullivan*, 875 F.2d 1160 (5th Cir.), cert. denied, 110 S. Ct. 573 (1989); *Kuritzky* v. *Blue Shield of Western New York, Inc.*, 850 F.2d 126, 128 (2d Cir. 1988), cert. denied, 109 S. Ct. 787 (1989); *Association of Seat Lift Manufacturers* v. *Bowen*, 858 F.2d 308 (6th Cir. 1988), cert. denied, 109 S. Ct. 1528 (1989). There is no reason for a different disposition here.

1. a. In *United States* v. *Erika*, *supra*, this Court held that 42 U.S.C. 1395ff precludes judicial review of Part B reimbursement determinations. *Michigan Academy*, 476 U.S. at 674-678, carves out an exception to that rule for direct challenges to the Secretary's regulations and directives that prescribe the method to be used by the carrier in making reimbursement determinations and calculating Part B benefits. As the *Michigan Academy* Court explained, 476 U.S. at 677-678, such methods bind the carrier hearing officer; therefore their legality cannot be considered in a carrier hearing. The district court correctly applied these principles to the particular circumstances of this case.

Petitioner seeks to evade the distinction between a misapplication by the carrier of the Secretary's reg-

ulations, and a challenge to those regulations themselves, by complaining that the carrier's deliberate refusal to process or review his claims has effectively denied him the administrative process prescribed by Congress. Petitioner argues that when a carrier refuses to process claims, there is, by definition, no "fair hearing" or any other action by the carrier on the claims. Thus, petitioner asserts, an action based on the contention that a carrier has refused to process claims cannot possibly be a "matter[] which Congress * * * [left] to be determined in a fair hearing conducted by the carrier." *Michigan Academy*, 476 U.S. at 678.

The courts below were correct to reject petitioner's novel theory. At bottom, petitioner's dispute is not with the Secretary's regulations but only with the actions of the carrier in applying those regulations to the handling of petitioner's claims. As such, it falls squarely within *Erika*'s proscription rather than *Michigan Academy*'s exception. Even assuming arguendo the truth of petitioner's allegations that the carrier wantonly refused to process his claims or his appeals—allegations conclusively refuted by the Secretary in the district court—his charge still amounts to nothing more than a claim that the carrier misapplied the procedures prescribed by the Secretary for processing and reviewing Medicare Part B claims. For the purpose of applying the distinction established in *Erika* and *Michigan Academy*, an allegation that the carrier has failed to process a claim is no different from any other assertion that the carrier did not properly follow the Secretary's procedural regulations in some particular manner. Nor is it appreciably different from a routine claim that the carrier erred in applying the Secretary's substantive regulations on such questions as the calculation of the

reasonable fee for services, or whether services are covered or medically necessary. In all these situations, whether procedural or substantive, the carrier can be wrong, even patently and egregiously wrong. However, so long as the claimant is not asserting the illegality of the Secretary's regulations or procedures themselves, Congress has determined that the carrier has the last word, and the courts are without authority to intervene.

b. At any rate, the issue concerning the precise dividing line between claims that are precluded by *Erika* and those that are allowed by *Michigan Academy* is of little continuing importance since Congress has amended 42 U.S.C. 1395ff to permit judicial review of benefit amount determinations under Part B where the aggregate amount in controversy is $1000 or more. This new provision means that in the future, if any provider wishes to assert that the carrier refused to process his claims for reimbursement or to hear his appeal, he can proceed to the district court.[2] Moreover, even with regard to still-pending claims for services provided prior to January 1, 1987, this case is too unimportant to warrant this Court's attention. Petitioner has not cited any prior reported case in which a provider or a beneficiary

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[2] Although the amended Section 1395ff allows district court review of a decision to deny a claim only after a hearing, any future provider who alleges that he was wrongfully denied a hearing will be able to allege and prove that the carrier failed to provide him with the required hearing even though he took all necessary steps to request a hearing, either after an initial denial and the carrier's decision to uphold the denial after review, or after the provider requested an oral hearing when the carrier failed to act on his claim within 60 days. If the district court agrees with such an allegation, it presumably will remand the claim to the carrier for the required hearing.

alleged that the carrier had failed to process his claim or his appeal, and we are aware of no such prior or pending cases. There is thus no reason for this Court to decide whether judicial review of this peculiar type of claim is precluded.

2. Petitioner also alleges that because his claim is based in part on denial of due process, the district court had jurisdiction over his claim that the carrier committed a constitutional tort under *Bivens* v. *Six Unknown Named Agents of Federal Bureau of Narcotics*, 403 U.S. 388 (1971). The district court rejected this contention, relying on *Schweiker* v. *Chilicky*, 108 S. Ct. 2460 (1988). There, this Court held that a *Bivens* remedy was not available for actions based on claims for benefits under the social security disability program, because Congress has already created an elaborate system for review of those claims. The statutory provisions and the Secretary's regulations similarly establish elaborate procedures for processing Part B claims and appealing their denial—procedures that this Court held in *Erika* were intended by Congress to be exclusive. As this Court explained in *Chilicky* and in *Bush* v. *Lucas*, 462 U.S. 367 (1983), courts should not create a new remedy of constitutional dimension when Congress has already created a remedy that it deems adequate. Allowing a *Bivens* remedy for an alleged procedural violation involving a Part B claim would undermine Congress's decision to provide a comprehensive administrative scheme for handling these claims.

Petitioner's allegation that the carrier here "frustrated" the application of the Part B administrative scheme is similarly unavailing. The inquiry under *Bush* and *Chilicky* is not over whether the plaintiff actually received relief under the alternative remedy, but whether it is appropriate for the courts to create

a new type of remedy when Congress already provided an adequate one through a comprehensive administrative scheme.[3] Petitioner's allegation that the available remedy in the instant case was not actually provided to him is not a challenge to the adequacy of the administrative remedy prescribed by Congress, but only a challenge to the application of the remedial procedures in his own case.[4]

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[3] Petitioner cites (Pet. 6 n.1) a decision of the Federal Circuit (not the D.C. Circuit, as he contends) holding that *Chilicky* does not apply where the defendant has "frustrated" the alternative avenue of relief. *Ysasi* v. *Rivkind*, 856 F.2d 1520, 1528 (Fed. Cir. 1988). In that case, however, the plaintiff alleged that a Border Patrol agent frustrated his ability administratively to challenge the seizure of his truck by turning the truck over to the finance agency, which apparently mooted the administrative appeal. In the present case, in contrast, petitioner simply asserts that the carrier failed to provide him with the process required by regulation—that is, that the body charged with providing the remedy created by Congress erred in carrying out its duty with regard to petitioner's claims.

[4] At any rate, the amendment of Section 1395ff to provide judicial review of Part B claims for services provided after January 1, 1987, means that the question of the availability of a *Bivens* remedy for Part B claims in the absence of direct judicial review, like the statutory issue, has little prospective importance.

In footnotes, petitioner raises two other grounds for jurisdiction. First, he mentions mandamus as a possible means to avoid the preclusion of review in 42 U.S.C. 1395ff, and 1395ii (which provides that judicial review of Medicare Act claims shall be limited in accordance with the terms of 42 U.S.C. 405(h)) (Pet. 6 n.2). This Court has not definitively addressed, in the wake of *Michigan Academy*, whether mandamus jurisdiction might be available over actions such as petitioner's involving Medicare Part B claims. However, there is no reason for the Court to consider the issue here,

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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FEBRUARY 1990

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where the possibility is only casually invoked by petitioner in his petition, and apparently was neither presented nor argued to the district court or the court of appeals. See Plaintiff-Appellant C.A. Br.

Petitioner also cites diversity jurisdiction (Pet. 7 n.3) as a possible basis for federal judicial review. First of all, there is a serious question whether the parties here could satisfy the requirement of diversity, since the carrier is not a proper defendant in its own right but stands in the shoes of the Secretary. See *Erika*, 456 U.S. at 206 n.4; *Anderson* v. *Occidental Life Insurance Co.*, 727 F.2d 855, 856 (9th Cir. 1984); *Peterson* v. *Weinberger*, 508 F.2d 45, 50-52 (5th Cir.), cert. denied, 423 U.S. 830 (1975). In any event, the Act's carefully drawn provisions, which the Court in *Erika*, 456 U.S. at 206-211, held evince a clear congressional intent to bar judicial review of the carrier's determination of the amount of benefits payable under Part B, equally preclude diversity as well as federal question jurisdiction.

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No. 89-811

IN THE

Supreme Court of the United States

OCTOBER TERM, 1989

MARVIN NEIMAN d/b/a
CONCOURSE NURSING HOME,

Petitioner,

vs.

SECRETARY OF THE UNITED STATES DEPARTMENT
OF HEALTH AND HUMAN SERVICES, and
THE TRAVELERS INSURANCE COMPANIES,

Respondent.

REPLY BRIEF ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES SUPREME COURT

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TABLE OF AUTHORITIES

REPLY BRIEF

Contrary to the underlying theme of Respondents' Brief, the issue set forth in the instant case – whether a party may be wholly deprived of a forum, both administrative and judicial, for review of an administrative agency's frustration of that party's access to the administrative review process – is of far reaching significance. Judge Sifton of the Eastern District of New York, and the Second Circuit, through its affirmance, have expanded the holdings *Bush v. Lucas*, 462 U.S. 367, 103 S.Ct. 2404 (1983), and *Schweiker v. Chilicky*, ____ U.S. ____, 108 S.Ct. 2460 (1988) to the Medicare context. Thus, *Bivens* actions have been severely limited, if not precluded, for a due process violation by a federal actor in the Medicare context. *See, Bivens v. Six Unknown Named Agents of the Federal Bureau of Narcotics*, 403 U.S. 667, 106 S.Ct. 2022 (1986); *Davis v. Passman*, 442 U.S. 228, 99 S.Ct. 2264 (1979) (Bivens action extended to Fifth Amendment context).

In fact, the issue of this case reaches beyond the Medicare context to all areas governed by administrative agencies. It is clear that the lower federal courts are struggling in this area and this case presents the ideal opportunity for this Court to set forth some guidance.

The fact that this type of "frustration" by an administrative agency is found in other administrative areas is aptly demonstrated by *Ysasi v. Rivkind*, 856 F.2d 1520 (Fed. Cir. 1988). Ysasi, an American citizen, was stopped while driving his truck by a border patrol agent (a division of the Immigration and Naturalization Service, "I.N.S."). When the agent learned that Ysasi was illegally transporting his brother-in-law, an illegal alien, he seized Ysasi's truck. Ysasi went through a number of prescribed administrative mechanisms in an attempt to get his truck back. In following the procedures carefully, he (1) requested and was granted an administrative interview; (2) filed an administrative claim; and (3) requested a bond waiver.

However, instead of following the prescribed administrative procedures, I.N.S., without considering plaintiff's request for

waiver of bond, remitted plaintiff's truck through a summary forfeiture proceeding to a company which had in the meantime filed a lien against it. The court held that although a comprehensive statutory and regulatory scheme was available, Ysasi was entitled to judicial review where the administrative agency itself had "frustrated" his use of the scheme.[1] *Ysasi*, at 1528.

This situation is identical to the circumstances presented in the instant case. Concourse was routinely denied all of its Part B claims by Travelers Insurance Company.[2] Concourse, like Ysasi, attempted to avail itself of the available administrative process by appealing the denials. However, Travelers refused to process the appeals applications, thus completely "frustrating" Concourse's attempts to use the administrative process. Concourse was left with no other recourse except the judicial system, which has also denied it access for review.

Clearly, the situation wherein a plaintiff is "frustrated" in pursuit of administrative remedies is not so singular that a decision by this Court would be "of little continuing importance." (Respondent's Brief, P. 8) On the contrary, such a decision would provide a barrier for abuse of authority by *all* administrative agencies in administration of the statutory schemes designed to protect the individual in the absence of judicial protections.

Moreover, this case is not appropriate for application of the regulation/application dichotomy set forth in *United States v. Erika, Inc.*, 456 U.S. 201, 102 S.Ct. 1650 (1982), *Bowen v.*

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[1] *Ysasi* thus carved a specific exception to *Shweiker v. Chilicky*, *supra*. (wherein the Court refused to allow a *Bivens* action for an alleged Fifth Amendment violation by the state official who administered the social security disability benefits program).

[2] Respondent alleges that the majority of petitioner's bills were in fact processed (*See*, Respondent's Brief, p. 4). It should be noted that this was never found by the court below, and was fiercely contested by petitioner. Respondent should not now be allowed to rely on such unfounded allegations. Moreover, the numbers are clearly inaccurate. Even if taken on its face, the Secretary only accounts for 376 of the alleged 2,200 bills not processed.

Michigan Academy of Family Physicians, 476 U.S. 667, 106 Sup. Ct. 2023 (1986), and *Kuritzsky v. Blue Shield of Western New York*, 850 F.2d 126 (2d Cir. 1988), *cert. denied*, 109 S.Ct. 787 (1989). That methodology, which provides either administrative or judicial review for all claims, only makes sense where all the actors "play fair." But where a party "frustrates" the administration of the administrative scheme, and judicial review is not enumerated by the Medicare statute, then federal jurisdiction against the wrongdoer is appropriate under *Bivens*. Such is the situation at hand.

Finally, from the beginning of this case, the government has persistently refused to recognize that Travelers Insurance Company is being sued as a party in its individual capacity. The very basis of a *Bivens* action is to sue the *individual* actors acting "under color of [federal] law." The government is not responsible for defending Travelers and its argument that it is the "real party in interest" is fallacious. As such, Petitioner's argument for diversity jurisdiction must hold fast since Travelers is Connecticut corporation while plaintiff is located in New York State. (Petitioners Brief p. 7, n. 3).

In a recent decision of the United States District Court of New Jersey, (rendered subsequently to the instant Petition) the District Court rejected the Secretary of Health and Human Services arguments that it was the "real party of interest" and that the carrier only a nominal defendant. In that case the government was not named as a defendant and did not officially intervene in the action. The Court found that "the government's only connection with this action is to represent [the carrier]." *Lifechem, Inc. v. The Prudential Insurance Co. of America*, No. 89 Civ. 2941 (N.J.D.C. December 12, 1989). Significantly, the Court acknowledged that diversity of citizenship would have provided jurisdiction for the case had the carrier been of different state citizenship than plaintiff. *Lifechem*, at 10.

For the reasons stated above and those stated in the initial brief in support of the Petition for Certiorari, this Court should

grant certiorari to review the Court of Appeal's decision which, in effect, wholly denied petitioner *any* forum for review of its claims.

Respectfully submitted,

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